CLIENT INTAKE FORM- THERAPEUTIC MASSAGE

Amy Wilson Massage

Personal Information:

Name _____ Date _____

Address _____ Phone _____

City/State/Zip _____ Email _____

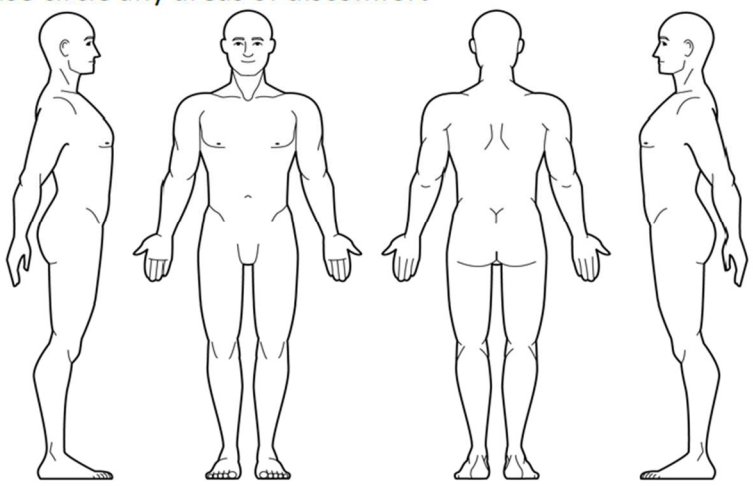
Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

The following information will be used to help plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

1. What are your treatment goals for today's session? _____
2. Have you ever had a professional massage? Yes No
   If yes, how often do you receive massage therapy? _____
3. Do you have difficulty lying on your front, back, or side? Yes No
   If yes, please explain. _____
4. Do you have allergies or sensitivities to oils, lotions, or ointments? Yes No
   If yes, please explain. _____
5. Do you sit for long periods of time at a workstation, computer, or driving? Yes No
   If yes, please describe. _____
6. Do you perform repetitive movements in your work, sports, or hobbies? Yes No
   If yes, please describe. _____
7. Is there an area of the body where you are experiencing tension, stiffness, pain, or other discomfort?
   Yes No
   If yes, please explain. _____
8. What is your stress level on a scale of 1-10? _____

Please circle any areas of discomfort



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Medical History

In order to provide a safe and effective massage session, I need to gather general information about your medical history.

9. Are you currently under medical supervision? Yes No
   If yes, please explain. _____
10. Are you currently taking any medications? Yes No
    If yes, please list. _____
11. Please check any of the following that apply to you.

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture or surgery
( ) artificial joint
( ) recent strains/sprains
( ) allergies
( ) history of stroke
( ) heart condition
( ) high/low blood pressure
( ) varicose veins/phlebitis
( ) atherosclerosis
( ) DVT/blood clots
( ) epilepsy
( ) headaches/migraines
( ) cancer/tumors
( ) diabetes
( ) carpal tunnel syndrome/thoracic outlet syndrome
( ) osteoporosis
( ) tennis or golfer's elbow
( ) IBS/Crohn's disease
( ) joint disorder/ tendonitis/bursitis/osteoarthritis
( ) TMJ
( ) tingling/numbness
( ) spinal problems
( ) asthma or breathing difficulty
( ) pregnant How many weeks? ____

Please explain any condition that you have marked above? _____
_____
_____

Please list any other medical conditions that the massage therapist should be aware of to provide a safe and effective treatment? _____

I _____ (print name) understand that the massage I received is provided for the basic purpose of relaxation, stress relief, and the relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am experiencing. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and nothing said in the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Amy Wilson, LMT, RYT200 updated of all changes in my health, medications, and injuries and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client _____ Date _____
Signature of Massage Therapist _____ Date _____